

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-049258

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

12558

STATE FILE NUMBER

FILED DEC 27 1963

1. PLACE OF DEATH

a. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only)
OR TOWN St. LouisLength of stay in 1b
17-daysc. FULL NAME OF (If NOT in hospital, give location)
HOSPITAL OR INSTITUTION Alexian Bros. Hosp.Inside Limits
Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE Missouri b. COUNTY

c. CITY OR TOWN St. Louis

Inside Limits
Yes ☒ No ☐d. STREET ADDRESS (If outside, give location)
5205 Fairview Ave.Reside on Farm
Yes ☐ No ☒3. NAME OF DECEASED
(Type or print)First Middle Last
Lillian G. Blake4. DATE OF DEATH Month Day Year
Dec. 17, 19635. SEX
Female6. COLOR OR RACE
White7. Married ☐ Never Married ☐
Widowed ☒ Divorced ☐8. DATE OF BIRTH
11/12/939. AGE (last birthday)
70IF UNDER 1 YEAR
Months Days Hours Min.IF UNDER 24 HR
Months Days Hours Min.10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housekeeping10b. KIND OF BUSINESS OR INDUSTRY
At Home11. BIRTHPLACE (City and state or country)
Springfield, Mo.12. CITIZEN OF WHAT COUNTRY
U.S.A.

13a. FATHER'S NAME

Henry Haid

13b. MOTHER'S MAIDEN NAME

Mollie Wayne

14. NAME OF HUSBAND OR WIFE

Hardin Blake

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes, give war or dates of service)
no16. SOCIAL SECURITY NO.
unknown17. INFORMANT Address
John Peters - 5205 Fairview Ave.18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cerebral Hemorrhage
with Rt. Hemiplegia
Hypertensive Arteriosclerosis
of HeartINTERVAL BETWEEN
ONSET AND DEATH
19 daysConditions, if any,
which gave rise to
above cause (a),
stating the under-
lying cause last.

DUE TO (b)

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the immediate cause of death
disease condition given in PART I (a)
443xIf deceased was female was there a pregnancy in last 90 days.
☐ Yes ☒ No ☐ Unknown19. WAS AUTOPSY PERFORMED?
YES ☐ NO ☒20a. ACCIDENT SUICIDE HOMICIDE
☐ ☐ ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour Month, Day, Year
a.m. p.m.20d. INJURY OCCURRED
WHILE AT WORK ☐
NOT WHILE AT WORK ☐20e. PLACE OF INJURY (e.g., in or about home,
farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from Jan 26 - 1962 to Dec. 17 - 1963 and last saw her alive on Dec. 17 - 1963
Death occurred at 1:05 P. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title)

22b. ADDRESS

22c. DATE SIGNED

23a. BURIAL, CREMATION,
REMOVAL (Specify)
Removal

23b. DATE

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION (City, town, or county) (State)

24. FUNERAL DIRECTOR

ADDRESS

25. DATE RECD. BY LOCAL REG.

26. REGISTRAR'S SIGNATURE

WACKER-HELDERLE-3634 Gravois Ave.

DEC 19 1963

Loan Smith. M.D.

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION
BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

Licensed Embalmer No.

P. O. Address

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.